



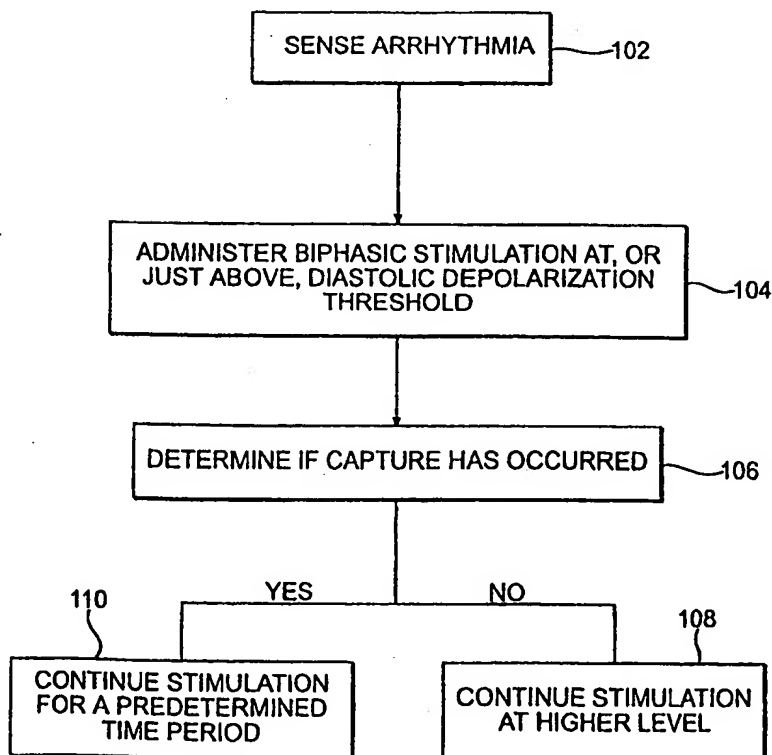
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(54) Title: ANTITACHYCARDIAL PACING

(57) Abstract

Protocols for antitachycardial pacing including biphasic stimulation administered at, or just above, the diastolic depolarization the shold potential; biphasic or conventional stimulation initiated at, or just above, the diastolic depolarization threshold potential, reduced, upon capture, to below threshold; and biphasic or conventional stimulation administered at a level set just below the diastolic depolarization threshold potential. These protocols result in reliable cardiac capture with a lower stimulation level, thereby causing less damage to the heart, extending battery life, causing less pain to the patient and having greater therapeutic effectiveness. In those protocols using biphasic cardiac pacing, a first and second stimulation phase is administered. The first stimulation phase has a predefined polarity, amplitude and duration. The second stimulation phase also has a predefined polarity, amplitude and duration. The two phases are applied sequentially. Contrary to current thought, anodal stimulation is first applied and followed by cathodal stimulation. In this fashion, pulse conduction through the cardiac muscle is improved together with the increase in contractility.



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1 **Title:** **ANTITACHYCARDIAL PACING**

2 **Inventor:** Morton M. Mower, M.D.

3 **Field of the Invention**

4 The present invention relates generally to implantable cardioverter/defibrillator with
5 antitachycardial pacing capabilities and/or a method of such pacing.

6 **Background of the Invention**

7 The typical implantable cardioverter/defibrillator (ICD) delivers an initial electrical
8 countershock within ten to twenty seconds of arrhythmia onset, thereby saving countless
9 lives. Improved devices have antitachycardia pacing capabilities in addition to
10 cardioverting/defibrillating functions. These ICDs are capable of different initial responses to
11 one or more tachycardia as well as a programmable sequence of responses to a particular
12 arrhythmia.

13 The output energy level is generally set by a physician in accordance with a patient's
14 capture threshold, determined at the time of heart implantation. This threshold represents the
15 minimum pacing energy required to reliably stimulate a patient's heart. However, due to
16 trauma associated with the stimulation, scar tissue grows at the interface between the
17 implanted cardiac pacer leads and the myocardium. This scar tissue boosts the patient's
18 capture threshold. To insure reliable cardiac capture, the output energy level is thus generally
19 set at a level which is a minimum of two times greater than the initially measured capture
20 threshold. A drawback to such an approach is that the higher stimulation level causes more
21 trauma to the cardiac tissue than would a lower level of stimulation, and hence promotes the
22 formation of scar tissue, thereby boosting the capture threshold.

23 The higher stimulation level also shortens battery life. This is not desirable, as a

1 shorter battery life necessitates more frequent surgery to implant fresh batteries.

2 Another drawback is the potential for patient discomfort associated with this higher
3 stimulation level. This is because the higher stimulation level can stimulate the phrenic or
4 diaphragmatic plexus or cause intercostal muscle pacing.

5 Lastly, the higher stimulation is less effective, due to entry block.

6 A need therefore exists for an ICD that can achieve reliable cardiac capture with a
7 lower stimulation level, thereby causing less damage to the heart, extending battery life,
8 causing less pain to the patient and having greater therapeutic effectiveness than current
9 ICDs. A need also exists for an ICD that can better entrain the heart and can entrain portions
10 of the heart from a greater distance.

11 **Summary of the Invention**

12 It therefore is an object of the present invention to provide an ICD with
13 antitachycardial pacing capabilities, wherein the stimulation is administered with a voltage
14 either at, just above, or just below the diastolic depolarization threshold potential.

15 It is another object of the present invention to sense whether cardiac capture has
16 occurred, and if not, to administer additional stimulation.

17 It is another object of the present invention to provide the additional stimulation at a
18 slightly higher voltage level than that level of stimulation which resulted in no capture.

19 It is another object of the present invention to repeat the stimulation - sensing cycle
20 until cardiac capture has occurred.

21 It is another object of the present invention to provide stimulation using a biphasic
22 waveform.

23 The present invention accomplishes the above objectives by providing an implantable
24 cardioverter-defibrillator with a unique constellation of features and capabilities. Protocols

disclosed include:

1/ biphasic stimulation administered at, or just above, the diastolic depolarization threshold potential;

2/ biphasic or conventional stimulation initiated at, or just above, the diastolic depolarization threshold potential, reduced, upon capture, to below threshold; and

3/ biphasic or conventional stimulation administered at a level set just below the diastolic depolarization threshold potential.

As mentioned, the antitachycardial pacing protocols of the present invention can be used in conjunction with biphasic pacing. The method and apparatus relating to biphasic pacing comprises a first and second stimulation phase, with each stimulation phase having a polarity, amplitude, shape, and duration. In a preferred embodiment, the first and second phases have differing polarities. In one alternative embodiment, the two phases are of differing amplitude. In a second alternative embodiment, the two phases are of differing duration. In a third alternative embodiment, the first phase is in a chopped wave form. In a fourth alternative embodiment, the amplitude of the first phase is ramped. In a fifth alternative embodiment the first phase is administered over 200 milliseconds after completion of a cardiac beating/pumping cycle. In a preferred alternative embodiment, the first phase of stimulation is an anodal pulse at maximum subthreshold amplitude for a long duration, and the second phase of stimulation is a cathodal pulse of short duration and high amplitude. It is noted that the aforementioned alternative embodiments can be combined in differing fashions. It is also noted that these alternative embodiments are intended to be presented by way of example only, and are not limiting.

Enhanced myocardial function is obtained through the biphasic pacing of the present invention. The combination of cathodal with anodal pulses of either a stimulating or

1 conditioning nature, preserves the improved conduction and contractility of anodal pacing
2 while eliminating the drawback of increased stimulation threshold. The result is a
3 depolarization wave of increased propagation speed. This increased propagation speed
4 results in superior cardiac contraction leading to an improvement in blood flow and in
5 increased access to reentrant circuits. Improved stimulation at a lower voltage level also
6 results in reduction in scar tissue buildup thereby reducing the tendency of the capture
7 threshold to rise; reduction in power consumption leading to increased life for pacemaker
8 batteries; and decreased pain to the patient.

9 Brief Description of the Drawings

10 Figs. 1A-1C illustrate examples of methodologies for treating arrhythmias.

11 Fig. 2 illustrates a schematic representation of leading anodal biphasic stimulation.

12 Fig. 3 illustrates a schematic representation of leading cathodal biphasic stimulation.

13 Fig. 4 illustrates a schematic representation of leading anodal stimulation of low level
14 and long duration, followed by conventional cathodal stimulation.

15 Fig. 5 illustrates a schematic representation of leading anodal stimulation of ramped
16 low level and long duration, followed by conventional cathodal stimulation.

17 Fig. 6 illustrates a schematic representation of leading anodal stimulation of low level
18 and short duration, administered in series followed by conventional cathodal stimulation.

19 Fig. 7 illustrates an implantable cardioverter/defibrillator useable for implementing
20 embodiments of the present invention.

21 Description of the Preferred Embodiments

22 The present invention relates to the use of antitachycardial pacing to break up
23 arrhythmia in the atrium. Figs. 1A through 1C illustrate examples of methodologies for
24 treating arrhythmias.

Fig. 1A illustrates a first methodology. Here, a sensor senses the onset of arrhythmia **102**. In a preferred embodiment, this sensor comprises an antitachycardial pacing algorithm. Biphasic stimulation is then administered **104**. In varying embodiments, this stimulation is either at, or just above the diastolic depolarization threshold. The ICD determines whether capture has occurred **106**. If capture has not occurred, then stimulation continues at a slightly higher level **108**. This stimulation - capture check - boost stimulation cycle continues until capture occurs. If capture has occurred, then stimulation is continued for a predetermined period of time **110**. In a preferred embodiment, stimulation is administered as long as the arrhythmia persists.

In a preferred embodiment, stimulation pulses are administered at 80 to 100 percent of the intrinsic rate with an approximately one to two second pause between each set of stimulation pulses. Then either the number of pulses increases, or the timing between pulses is adjusted. For example, in a preferred embodiment, the first pulse sequence can be at 80 percent of the intrinsic heart rate, the second pulse sequence at 82 percent, the third pulse sequence at 84 percent, and so on. In a preferred embodiment a plurality of feedback loops provide data such that the voltage can be adjusted to constantly skirt the capture threshold. Stimulation is continued until the rhythm reverts.

Fig. 1B illustrates a second methodology. Here, a sensor senses the onset of arrhythmia **112**. In varying embodiments of the second method, either biphasic or conventional stimulation is then administered **114**. This stimulation level is set at or just above the diastolic depolarization threshold potential. The ICD determines whether capture has occurred **116**. If capture has not occurred, then stimulation continues at a slightly higher level **118**. This stimulation - capture check - boost stimulation cycle continues until capture occurs. If capture has occurred, then stimulation is gradually and continuously reduced to

below threshold, and continued 120. Then, if capture is lost, the stimulation is raised to a slightly higher level and is again gradually and continuously reduced. This entire sequence is repeated, such that the stimulation level hovers as close as possible to the lowest stimulation level which provides capture. Stimulation continues until the rhythm reverts, for example, when the antitachycardial pacing algorithm determines that pacing is no longer necessary.

Fig. 1C illustrates a third methodology. Here, a sensor senses the onset of arrhythmia 122. In varying embodiments of the third method, either biphasic or conventional stimulation is then administered 124. This stimulation level is set just below the diastolic depolarization threshold potential. The ICD determines whether capture has occurred 126. If capture has not occurred, then stimulation continues at a slightly higher level 128. This stimulation - capture check - boost stimulation cycle continues until capture occurs. If capture has occurred, then stimulation is continued at below threshold level 130. If capture is lost then the stimulation is raised to a slightly higher level and is gradually and continuously reduced. This entire sequence is repeated, such that the stimulation level hovers as close as possible to the lowest stimulation level which provides capture. Stimulation continues until the rhythm reverts, for example, when the antitachycardial pacing algorithm determines that pacing is no longer necessary.

Sensing

Sensing can be direct or indirect. For example, direct sensing can be based on data from sensing electrodes. The ICD of the present invention includes sensing circuits/electronics to sense an arrhythmia through one or more sensing and/or stimulating electrodes. The sensing electronics sense the cardiac activity as depicted by electrical signals. For example, as is known in the art, R-waves occur upon the depolarization of ventricular tissue and P-waves occur upon the depolarization of atrial tissue. By monitoring these

1 electrical signals the control/timing circuit of the ICD can determine the rate and regularity of
2 the patient's heart beat, and thereby determine whether the heart is undergoing arrhythmia.
3 This determination can be made by determining the rate of the sensed R-waves and/or P-
4 waves and comparing this determined rate against various reference rates.

5 Direct sensing can be based upon varying criteria; such as, but not limited to, primary
6 rate, sudden onset, and stability. The sole criteria of a primary rate sensor is the heart rate.
7 When applying the primary rate criteria, if the heart rate should exceed a predefined level,
8 then treatment is begun. Sensing electronics set to sudden onset criteria ignore those changes
9 which occur slowly, and initiate treatment when there is a sudden change such as immediate
10 paroxysmal arrhythmia. This type of criteria would thus discriminate against sinus
11 tachycardia. Stability of rate can also be an important criteria. For example, treatment with a
12 ventricular device would not be warranted for a fast rate that varies, here treatment with an
13 atrial device would be indicated.

14 In alternative embodiments, sensing can be indirect. Indirect sensing can be based on
15 any of various functional parameters such as arterial blood pressure, rate of the
16 electrocardiogram deflections or the probability density function (pdf) of the
17 electrocardiogram. For example, whether or not to administer treatment can also be affected
18 by pdf monitoring of the time the signal spends around the baseline.

19 Sensing can also be augmented by stimulating the atria and observing and measuring
20 the consequent effects on atrial and ventricular function.

21 Thus, in a preferred embodiment, sensing electronics are based upon multiple criteria.
22 In addition, the present invention envisions devices working in more than one chamber such
23 that appropriate treatment can be administered to either the atrium or the ventricle in response
24 to sensing electronics based upon a variety of criteria, including those described above as well

1 as other criteria known to those skilled in the art.

2 Stimulation

3 Electrical stimulation is delivered via lead(s) or electrode(s). These leads can be
4 epicardial (external surface of the heart) or endocardial (internal surface of the heart) or any
5 combination of epicardial and endocardial. Leads are well known to those skilled in the art;
6 see, for example, United States Patent Nos. 4662377 to Heilman et al., 4481953 to Gold et
7 al., and 4010758 to Rockland et al., each of which is herein incorporated by reference in its
8 entirety.

9 Lead systems can be unipolar or bipolar. A unipolar lead has one electrode on the
10 lead itself, the cathode. Current flows from the cathode, stimulates the heart, and returns to
11 the anode on the casing of the pulse generator to complete the circuit. A bipolar lead has two
12 poles on the lead a short distance from each other at the distal end, and both electrodes lie
13 within the heart.

14 With the reference to Fig. 7, an exemplary system by which the present invention may
15 be embodied is illustrated. An automatic implantable cardioverter/defibrillator 2 is implanted
16 within the body of the patient and has a pair of output terminals, an anode 4 and a cathode 6.
17 The ICD 2 is coupled to a flexible catheter electrode arrangement 8 having a distal electrode
18 10 and a proximal electrode 12, each associated with the patient's heart. Other electrode
19 configurations may be employed, such as ring-type electrodes. As for external electrodes, an
20 anodal electrode 24 may be employed. The automatic ICD 2 includes sensing and detecting
21 circuitry, as well as pulse generating circuitry, the output of the latter being coupled to the
22 implantable electrodes 10, 12. The ICD 2 senses an arrhythmic condition of the heart and, in
23 response thereto, issues or emits cardioverting or defibrillating pulses to the heart, through the
24 implantable electrodes 10, 12.

1 The catheter electrode 8 is inserted intravenously to a position such that the distal
2 electrode 10 is positioned in the right ventricular apex 14 of the heart and the proximal
3 electrode 12 is positioned in the superior vena cava region 16 of the heart. It should be
4 appreciated that, as the term is used herein, the superior vena cava 16 may also include
5 portions of the right atrium 18.

6 Conventional stimulation is well known to those skilled in the art and comprises
7 monophasic waveforms (cathodal or anodal) as well as multiphasic waveforms wherein the
8 nonstimulating pulses are of a minimal magnitude and are used, for example, to dissipate a
9 residual charge on an electrode.

10 **Figs. 2 through 6** depict a range of biphasic stimulation protocols. These protocols
11 have been disclosed in United States Patent Application No. 08/699,552 to Mower, which is
12 herein incorporated by reference in its entirety.

13 **Fig. 2** depicts biphasic electrical stimulation wherein a first stimulation phase
14 comprising anodal stimulus 102 is administered having amplitude 104 and duration 106.
15 This first stimulation phase is immediately followed by a second stimulation phase
16 comprising cathodal stimulation 108 of equal intensity and duration.

17 **Fig. 3** depicts biphasic electrical stimulation wherein a first stimulation phase
18 comprising cathodal stimulation 202 having amplitude 204 and duration 206 is administered.
19 This first stimulation phase is immediately followed by a second stimulation phase
20 comprising anodal stimulation 208 of equal intensity and duration.

21 **Fig. 4** depicts a preferred embodiment of biphasic stimulation wherein a first
22 stimulation phase, comprising low level, long duration anodal stimulation 302 having
23 amplitude 304 and duration 306, is administered. This first stimulation phase is immediately

1 followed by a second stimulation phase comprising cathodal stimulation 308 of conventional
2 intensity and duration. In differing alternative embodiments, anodal stimulation 302 is: 1) at
3 maximum subthreshold amplitude; 2) less than three volts; 3) of a duration of
4 approximately two to eight milliseconds; and/or 4) administered over 200 milliseconds post
5 heart beat. Maximum subthreshold amplitude is understood to mean the maximum
6 stimulation amplitude that can be administered without eliciting a contraction. In a preferred
7 embodiment, anodal stimulation is approximately two volts for approximately three
8 milliseconds duration. In differing alternative embodiments, cathodal stimulation 308 is: 1)
9 of a short duration; 2) approximately 0.3 to 1.5 milliseconds; 3) of a high amplitude; 4) in
10 the approximate range of three to twenty volts; and/or 5) of a duration less than 0.3
11 millisecond and at a voltage greater than twenty volts. In a preferred embodiment, cathodal
12 stimulation is approximately six volts administered for approximately 0.4 millisecond. In the
13 manner disclosed by these embodiments, as well as those alterations and modifications which
14 can become obvious upon the reading of this specification, a maximum membrane potential
15 without activation is achieved in the first phase of stimulation.

16 Fig. 5 depicts an alternative preferred embodiment of biphasic stimulation wherein a
17 first stimulation phase, comprising anodal stimulation 402, is administered over period 404
18 with rising intensity level 406. The ramp of rising intensity level 406 can be linear or non-
19 linear, and the slope can vary. This anodal stimulation is immediately followed by a second
20 stimulation phase comprising cathodal stimulation 408 of conventional intensity and duration.
21 In alternative embodiments, anodal stimulation 402: (1) rises to a maximum subthreshold
22 amplitude less than three volts; (2) is of a duration of approximately two to eight
23 milliseconds; and/or (3) is administered over 200 milliseconds post heart beat. In yet other
24 alternative embodiments, cathodal stimulation 408 is: (1) of a short duration; (2)

1 approximately 0.3 to 1.5 milliseconds; (3) of a high amplitude; (4) in the approximate range
2 of three to twenty volts; and/or (5) of a duration less than 0.3 milliseconds and at a voltage
3 greater than twenty volts. In the manner disclosed by these embodiments, as well as those
4 alterations and modifications which can become obvious upon the reading of this
5 specification, a maximum membrane potential without activation is achieved in the first
6 phase of stimulation.

7 **Fig. 6** depicts biphasic electrical stimulation wherein a first stimulation phase,
8 comprising series **502** of anodal pulses, is administered at amplitude **504**. In one
9 embodiment, rest period **506** is of equal duration to stimulation period **508**, and is
10 administered at baseline amplitude. In an alternative embodiment, rest period **506** is of a
11 differing duration than stimulation period **508**, and is administered at baseline amplitude.
12 Rest period **506** occurs after each stimulation period **508**, with the exception that a second
13 stimulation phase, comprising cathodal stimulation **510** of conventional intensity and
14 duration, immediately follows the completion of series **502**. In alternative embodiments: (1)
15 the total charge transferred through series **502** of anodal stimulation is at the maximum
16 subthreshold level; and/or (2) the first stimulation pulse of series **502** is administered over
17 200 milliseconds post heart beat. In yet other alternative embodiments, cathodal stimulation
18 **510** is: (1) of a short duration; (2) approximately 0.3 to 1.5 milliseconds; (3) of a high
19 amplitude; (4) in the approximate range of three to twenty volts, and/or (5) of a duration less
20 than 0.3 milliseconds and at a voltage greater than twenty volts.

21 Determining Cardiac Capture

22 Capture can be determined by multiple means. First, capture or the loss thereof, can
23 be determined by monitoring cardiac rhythm. Loss of capture can result in a change in timing
24 of the heart beat.

1 Second, capture can be monitored through the development of a template. The
2 template can be based on parameters such as electrocardiogram data, mechanical motion
3 and/or probability density function data. Where the template is established pre-stimulation, a
4 change in the baseline signifies capture. Where the template is established after capture has
5 occurred, a change in the template characteristics signifies loss of capture. The templates can
6 be established and/or updated at any time.

7 Once capture occurs the stimulation protocol of the entrained sites is adjusted as
8 illustrated by Figs. 1A through 1C.

9 Having thus described the basic concept of the invention, it will be readily apparent to
10 those skilled in the art that the foregoing detailed disclosure is intended to be presented by
11 way of example only, and is not limiting. Various alterations, improvements and
12 modifications will occur and are intended to those skilled in the art, but are not expressly
13 stated herein. These modifications, alterations and improvements are intended to be
14 suggested hereby, and within the scope of the invention. Further, the pacing pulses described
15 in this specification are well within the capabilities of existing pacemaker electronics with
16 appropriate programming. Accordingly, the invention is limited only by the following claims
17 and equivalents thereto.

1 What is claimed is:

2 1. An implantable cardioverter-defibrillator (ICD), the ICD comprising:

3 sensing means for sensing the onset of arrhythmia;

4 output means for delivering, in response to the sensing means, electrical stimulation
5 of a predetermined polarity, amplitude, shape and duration to cause application of biphasic
6 stimulation at a first intensity level selected from the group consisting of: at the diastolic
7 depolarization threshold, below the diastolic depolarization threshold, and above the diastolic
8 depolarization threshold; and

9 means for determining whether capture has occurred;

10 wherein biphasic stimulation comprises:

11 a first stimulation phase with a first phase polarity, a first phase amplitude,
12 a first phase shape and a first phase duration; and

13 a second stimulation phase with a second phase polarity, a second phase
14 amplitude, a second phase shape and a second phase duration.

15 2. The ICD as in claim 1, wherein in the event that the means for determining
16 determines that capture has not occurred, the output means increases the stimulation intensity
17 level by predefined increments until capture occurs.

18 3. The ICD as in claim 1, wherein in the event that the means for determining
19 determines that capture has occurred, the output means continues biphasic stimulation for a
20 predetermined period of time.

21 4. The ICD as in claim 1, wherein in the event that the means for determining
22 determines that capture has occurred, the output means halts biphasic stimulation.

23 5. The ICD as in claim 1, wherein the first phase polarity is positive.

24 6. The ICD as in claim 1, wherein the first phase amplitude is less than the second

1 phase amplitude.

2 7. The ICD as in claim 1, wherein the first phase amplitude is ramped from a baseline
3 value to a second value.

4 8. The ICD as in claim 7, wherein the second value is equal to the second phase
5 amplitude.

6 9. The ICD as in claim 7, wherein the second value is at a maximum subthreshold
7 amplitude.

8 10. The ICD as in claim 9, wherein the maximum subthreshold amplitude is about 0.5
9 to 3.5 volts.

10 11. The ICD as in claim 7, wherein the first phase duration is at least as long as the
11 second phase duration.

12 12. The ICD as in claim 7, wherein the first phase duration is about one to nine
13 milliseconds.

14 13. The ICD as in claim 7, wherein the second phase duration is about 0.2 to 0.9
15 milliseconds.

16 14. The ICD as in claim 7, wherein the second phase amplitude is about two volts to
17 twenty volts.

18 15. The ICD as in claim 7, wherein the second phase duration is less than 0.3
19 milliseconds and the second phase amplitude is greater than 20 volts.

20 16. The ICD as in claim 1, wherein the first stimulation phase further comprises a
21 series of stimulating pulses of a predetermined amplitude, polarity and duration.

22 17. The ICD as in claim 16, wherein the first stimulation phase further comprises a
23 series of rest periods.

24 18. The ICD as in claim 17, wherein applying the first stimulation phase further

comprises applying a rest period of a baseline amplitude after at least one stimulating pulse.

19. The ICD as in claim 18, wherein the rest period is of equal duration to the duration of the stimulating pulse.

20. The ICD as in claim 1, wherein the first phase amplitude is at a maximum subthreshold amplitude.

21. The ICD as in claim 20, wherein the maximum subthreshold amplitude is about 0.5 to 3.5 volts.

22. The ICD as in claim 1, wherein the first phase duration is at least as long as the second phase duration.

23. The ICD as in claim 1, wherein the first phase duration is about one to nine milliseconds.

24. The ICD as in claim 1, wherein the second phase duration is about 0.2 to 0.9 milliseconds.

25. The ICD as in claim 1, wherein the second phase amplitude is about two volts to twenty volts.

26. The ICD as in claim 1, wherein the second phase duration is less than 0.3 milliseconds and the second phase amplitude is greater than 20 volts.

27. The ICD as in claim 1, wherein the first stimulation phase is initiated greater than 200 milliseconds after completion of a cardiac beating cycle.

28. A method of operating an implantable cardioverter-defibrillator (ICD), the ICD having output means for delivering electrical stimulation of a predetermined polarity, amplitude, shape and duration, the method comprising:

sensing the onset of arrhythmia;

applying stimulation selected from the group consisting of biphasic stimulation and

1 conventional stimulation at a first intensity level selected from the group consisting of at the
2 diastolic depolarization threshold, below the diastolic depolarization threshold or above the
3 diastolic depolarization threshold;

4 determining whether capture has occurred;

5 increasing the stimulation intensity level by predefined increments until capture does
6 occurs; and upon capture,

7 continuing stimulation selected from the group consisting of biphasic stimulation and
8 conventional stimulation at a second intensity level below the diastolic depolarization
9 threshold.

10
11 29. A method of operating an implantable cardioverter-defibrillator (ICD), the
12 ICD having output means for delivering electrical stimulation of a predetermined polarity,
13 amplitude, shape and duration, the method comprising:

14 defining a first stimulation phase with a positive polarity, a first phase amplitude, a
15 first phase shape and a first phase duration, wherein said first phase amplitude is about 0.5 to
16 3.5 volts, wherein said first phase duration is about one to nine milliseconds and wherein said
17 first stimulation phase is initiated greater than 200 milliseconds after completion of a cardiac
18 beating cycle;

19 defining a second phase with a negative polarity, a second phase amplitude, a second
20 phase shape and a second phase duration, wherein said second phase amplitude is about four
21 volts to twenty volts and wherein said second phase duration is about 0.2 to 0.9 milliseconds;
22 and

23 sensing the onset of arrhythmia;

24 applying the first stimulation phase and the second stimulation phase in sequence to

1 the cardiac tissue;
2 determining whether capture has occurred; and
3 increasing the stimulation intensity level by predefined increments until capture
4 occurs.

5 **30.** A method of operating an implantable cardioverter-defibrillator (ICD), the
6 ICD having output means for delivering electrical stimulation of a predetermined polarity,
7 amplitude, shape and duration, the method comprising:

8 sensing the onset of arrhythmia;
9 applying biphasic stimulation at a first intensity level selected from the group
10 consisting of at the diastolic depolarization threshold, below the diastolic depolarization
11 threshold or above the diastolic depolarization threshold wherein biphasic stimulation
12 comprises:
13 a first stimulation phase with a first phase polarity, a first phase amplitude,
14 a first phase shape and a first phase duration; and
15 a second stimulation phase with a second phase polarity, a second phase
16 amplitude, a second phase shape and a second phase duration; and
17 determining whether capture has occurred.

18 **31.** An implantable cardiac stimulator device comprising:
19 plural electrodes;
20 sensing circuitry connected to the plural electrodes and adapted to sense the onset of
21 arrhythmia;
22 detecting circuitry connected to the sensing circuitry and adapted to detect whether
23 capture has occurred; and
24 pulse generating circuitry connected to the plural electrodes and adapted to generate,

1 in response to the sensing circuitry, electrical pulses of a predetermined polarity, amplitude,
2 shape and duration to cause application of biphasic stimulation at a first intensity level
3 selected from the group consisting of: at the diastolic depolarization threshold, below the
4 diastolic depolarization threshold, and above the diastolic depolarization threshold; and
5 wherein biphasic stimulation comprises:

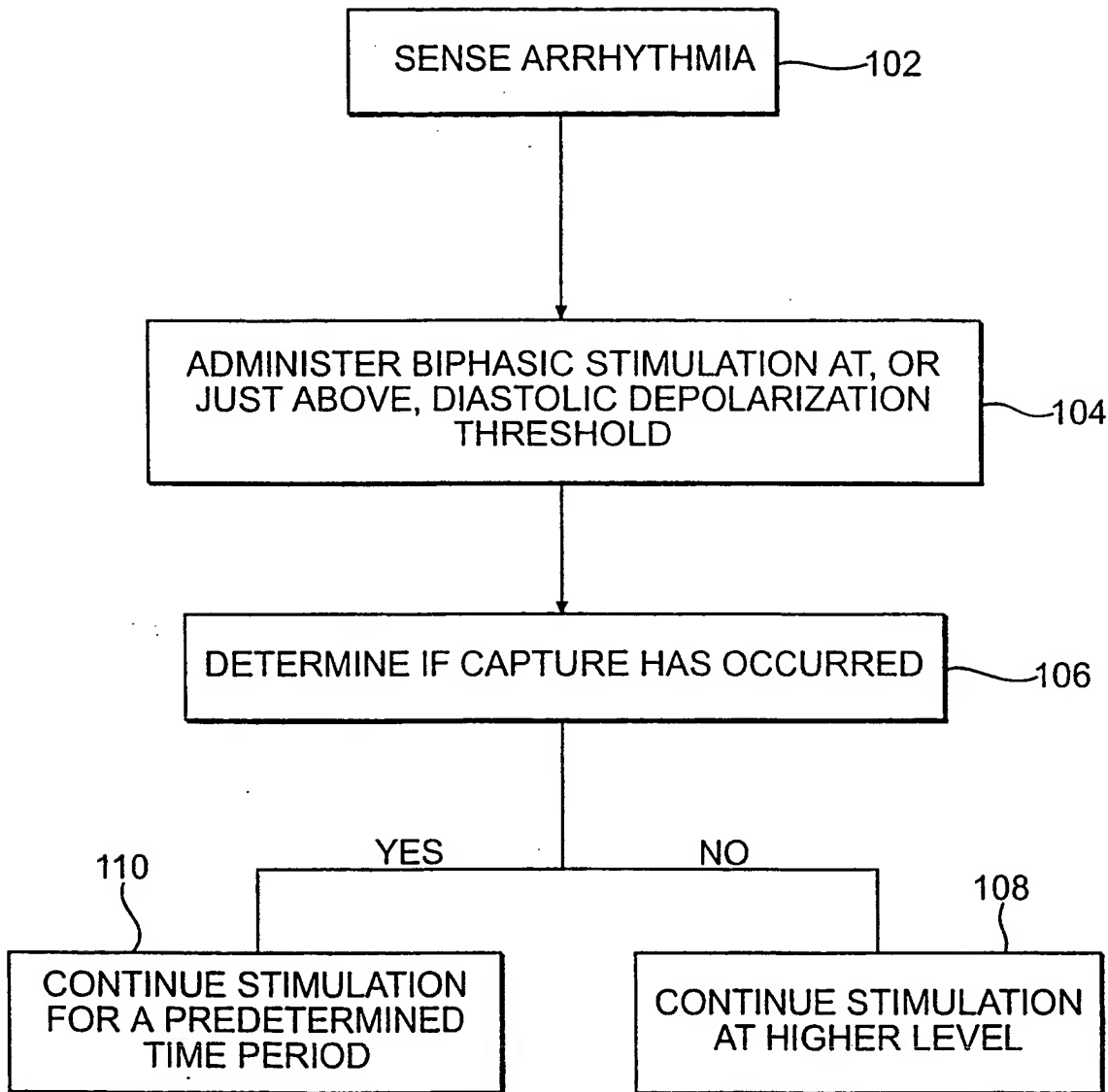
6 a first stimulation phase with a first phase polarity, a first phase amplitude,
7 a first phase shape and a first phase duration; and
8 a second stimulation phase with a second phase polarity, a second phase
9 amplitude, a second phase shape and a second phase duration.

10 **32.** The implantable cardiac stimulator device as in claim 31, wherein, in the event
11 that the detecting circuitry determines that capture has not occurred, the pulse generating
12 circuitry increases the stimulation intensity level by predefined increments until capture
13 occurs.

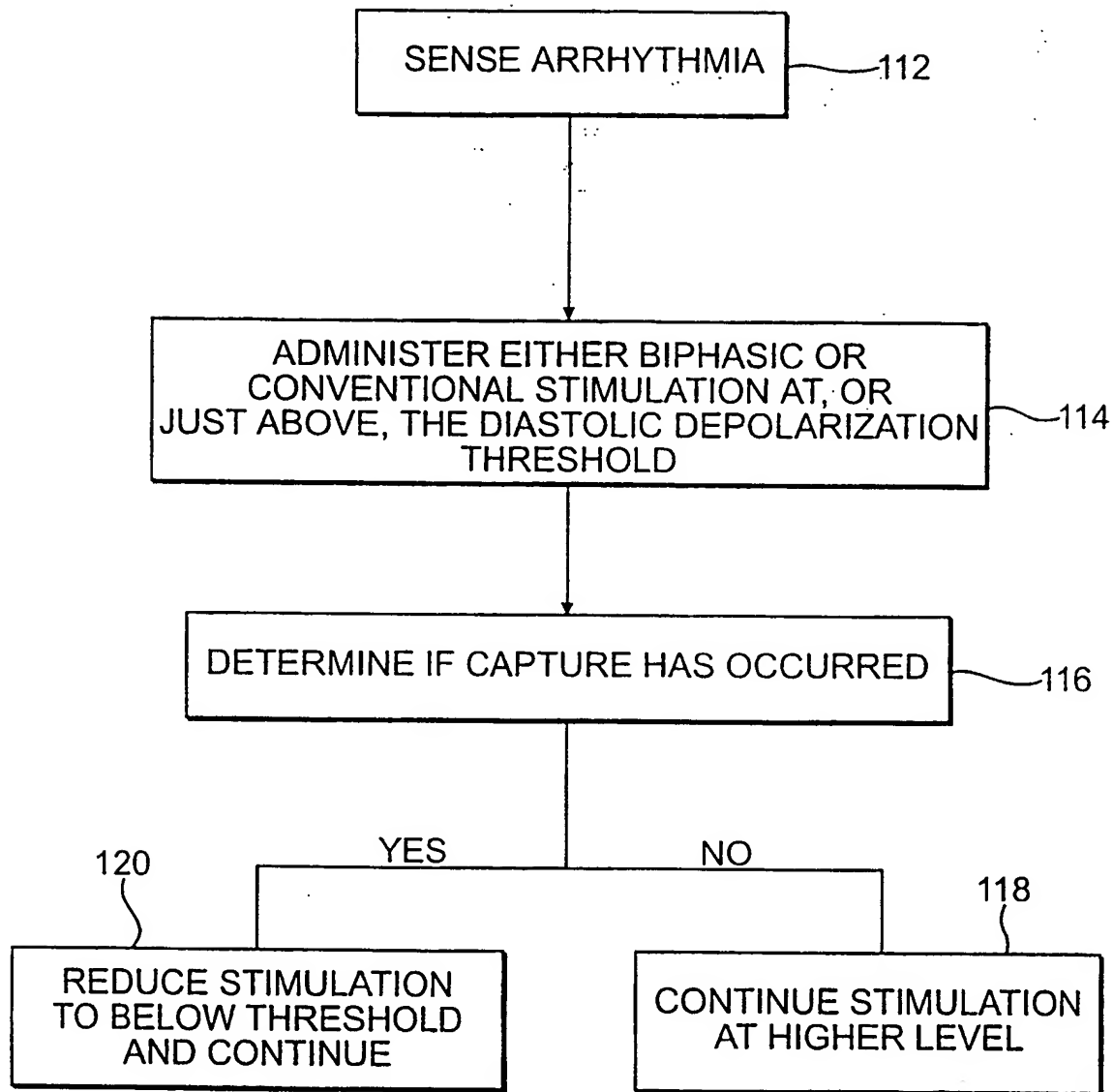
14 **33.** The implantable cardiac stimulator device as in claim 31, wherein, in the event
15 that the detecting circuitry determines that capture has occurred, the pulse generating circuitry
16 continues biphasic stimulation for a predetermined period of time.

17 **34.** The implantable cardiac stimulator device as in claim 31, wherein, in the event
18 that the detecting circuitry determines that capture has occurred, the pulse generating circuitry
19 halts biphasic stimulation.

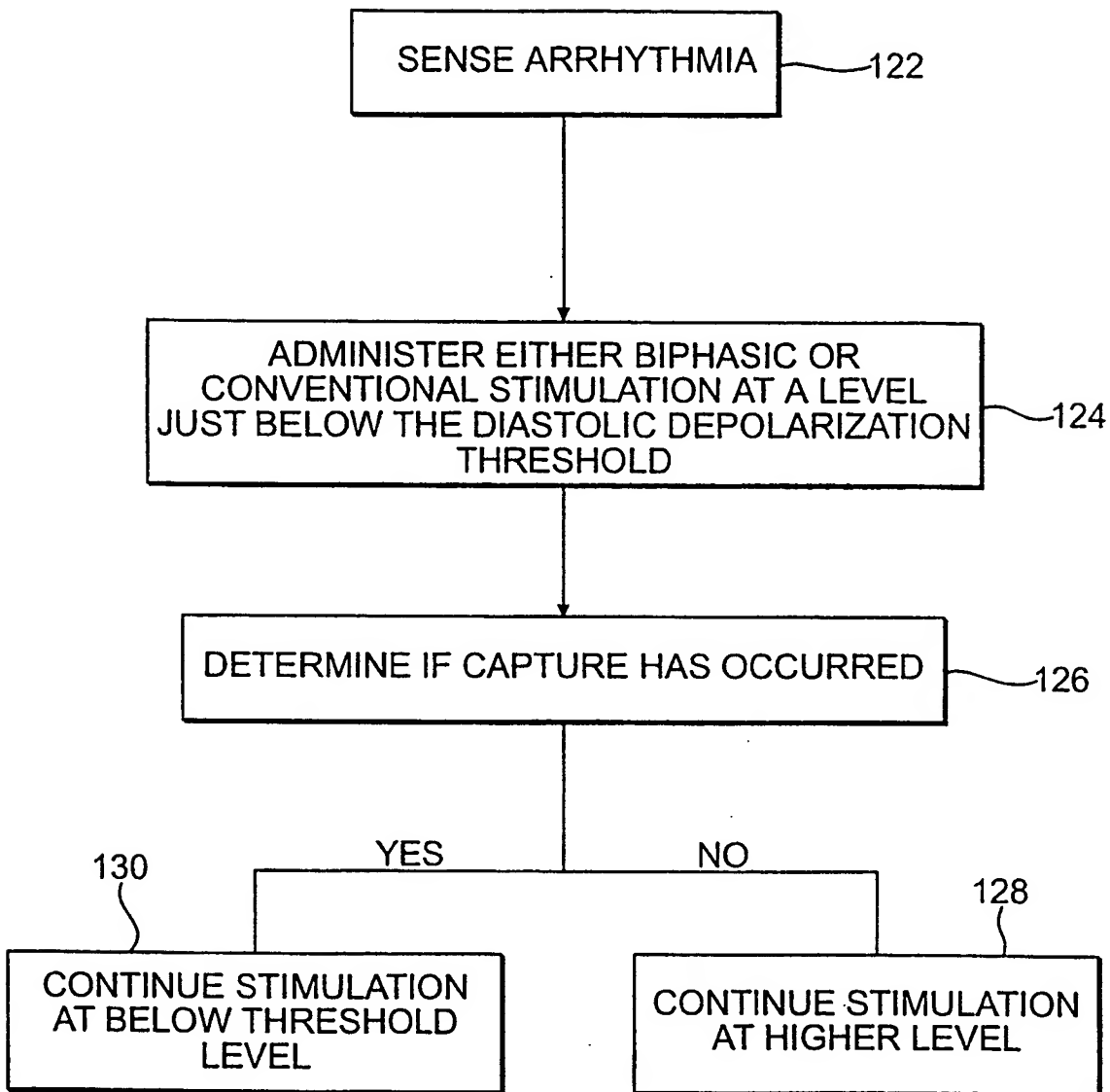
1/5

**FIG. 1A**

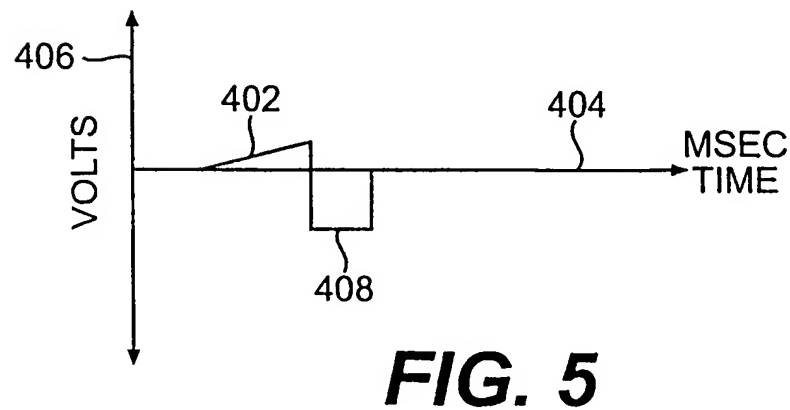
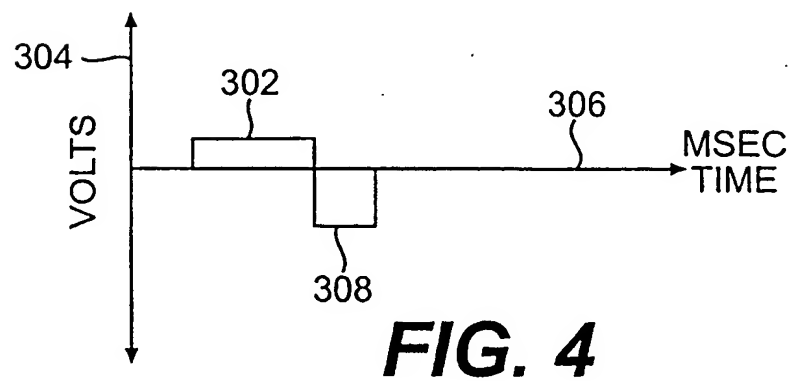
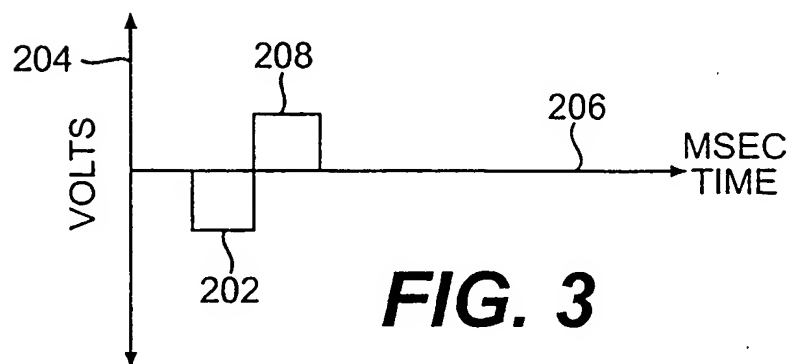
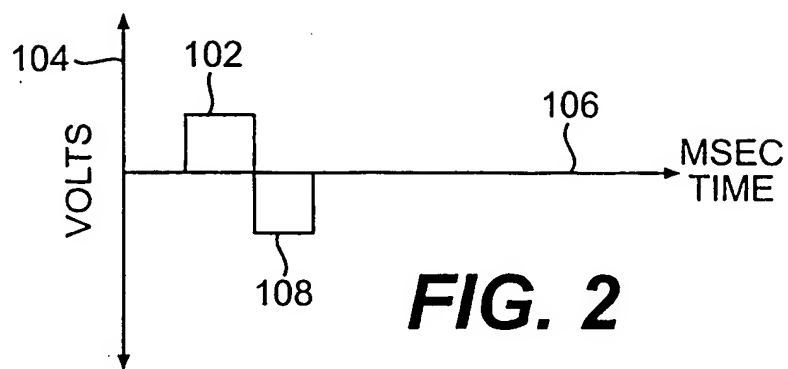
2/5

**FIG. 1B**

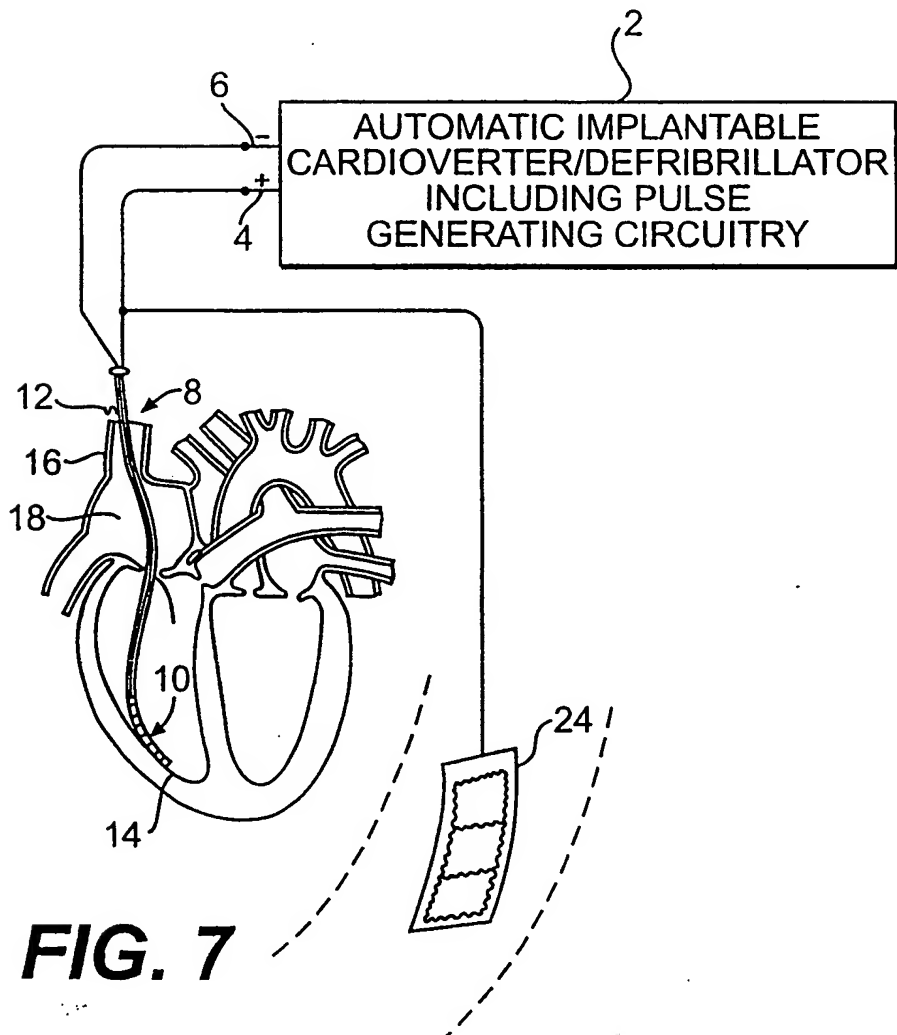
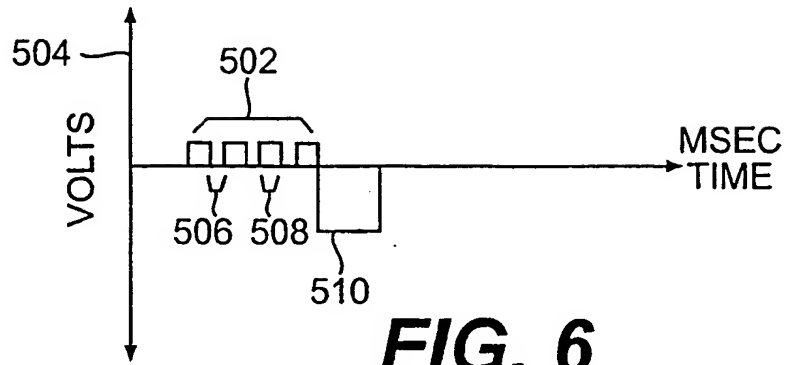
3/5

**FIG. 1C**

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INTERNATIONAL SEARCH REPORT

International Application No.

PCT/US 00/00928

A. CLASSIFICATION OF SUBJECT MATTER
 IPC 7 A61N1/37 A61N1/39

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

IPC 7 A61N

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
Y	US 5 105 810 A (COLLINS KENNETH A ET AL) 21 April 1992 (1992-04-21) column 6, line 24-26 column 9, line 1 -column 11, line 57; claims 1-11; figures 1-3,7,8	1-7,20, 22,31-34
Y A	US 5 718 720 A (PRUTCHI DAVID ET AL) 17 February 1998 (1998-02-17) column 15, line 7-18; figure 10	1-4, 31-34 5-27
Y A	EP 0 870 516 A (VITATRON MEDICAL BV) 14 October 1998 (1998-10-14) the whole document	5,6,22 7-21, 23-27, 31-34
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☒ Further documents are listed in the continuation of box C.

☒ Patent family members are listed in annex.

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Date of the actual completion of the international search

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C.(Continuation) DOCUMENTS CONSIDERED TO BE RELEVANT

Category *	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
Y	US 5 233 985 A (HUDRLIK TERRENCE R) 10 August 1993 (1993-08-10) column 2, line 42-55 column 7, line 5-23 column 8, line 68 -column 9, line 40 column 10, line 64 -column 12, line 37; figures 1,4-6	7,20
A	US 5 083 564 A (SCHERLAG BENJAMIN J) 28 January 1992 (1992-01-28) column 3, line 62 -column 4, line 31; claim 1	7,20
P,A	WO 99 36124 A (MOWER MORTON M) 22 July 1999 (1999-07-22) the whole document	1-27, 31-34
P,A	WO 00 01443 A (MOWER MORTON M) 13 January 2000 (2000-01-13) the whole document	1-27, 31-34
P,A	US 5 871 506 A (MOWER MORTON M) 16 February 1999 (1999-02-16) cited in the application the whole document	1-27, 31-34
P,A	WO 99 61101 A (MOWER MORTON M) 2 December 1999 (1999-12-02) the whole document	1-27, 31-34

INTERNATIONAL SEARCH REPORT

Information on patent family members

International Application No

PCT/US 00/00928

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
US 5105810 A	21-04-1992	EP 0468720 A	29-01-1992
US 5718720 A	17-02-1998	EP 0952872 A	03-11-1999
		WO 9825672 A	18-06-1998
EP 0870516 A	14-10-1998	US 5741312 A	21-04-1998
US 5233985 A	10-08-1993	US 5156149 A	20-10-1992
		US 5265603 A	30-11-1993
		AU 656163 B	27-01-1995
		AU 9172891 A	23-02-1993
		CA 2110686 A	04-02-1993
		DE 69119242 D	05-06-1996
		DE 69119242 T	05-12-1996
		EP 0594627 A	04-05-1994
		JP 2520355 B	31-07-1996
		JP 6503741 T	28-04-1994
		US 5370665 A	06-12-1994
		WO 9301863 A	04-02-1993
		AU 642039 B	07-10-1993
		AU 8400491 A	02-03-1992
		CA 2087264 A	11-02-1992
		DE 69105511 D	12-01-1995
		DE 69105511 T	13-04-1995
		EP 0542890 A	26-05-1993
		JP 2906351 B	21-06-1999
		JP 5509020 T	16-12-1993
		WO 9202274 A	20-02-1992
		US 5411529 A	02-05-1995
		AU 651989 B	11-08-1994
		AU 8316891 A	08-07-1992
		CA 2095601 A,C	13-06-1992
		DE 69104494 D	10-11-1994
		DE 69104494 T	09-02-1995
		EP 0561781 A	29-09-1993
		JP 2808363 B	08-10-1998
		JP 6502778 T	31-03-1994
		WO 9210236 A	25-06-1992
US 5083564 A	28-01-1992	US 5320642 A	14-06-1994
WO 9936124 A	22-07-1999	AU 2321199 A	02-08-1999
WO 0001443 A	13-01-2000	AU 8282098 A	24-01-2000
		NO 20000162 A	01-03-2000
US 5871506 A	16-02-1999	NONE	
WO 9961101 A	02-12-1999	AU 4198499 A	13-12-1999

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